Critical Incident and Death Reporting Form

Client Name:_____ **Client Social Security No:** _____ - ____ -_____ **Client ID No:**_____

This form is used to report critical incidents and deaths for any person receiving mental health, developmental disabilities and/or substance abuse (mh/dd/sa) services. Facilities licensed under G.S. 122C (except hospitals) and unlicensed providers of periodic or community-based mh/dd/sa services must submit the form. Failure to complete this form, as required by North Carolina Administrative Code 10A NCAC 27G .0600, may result in administrative actions being taken against the provider's license or enrollment. **NOTE: Effective July 1, 2003, this form also replaces the Report of Death to DHHS Form for reporting deaths from unnatural causes.**

Instructions: Complete and submit this form within 72 hours of a critical incident or death. ♦ In addition, report immediately deaths that occur within 7 days of restraint or seclusion of a client to NC Division of Facility Services. ♦ Complete one form for each client and submit to the host and home area authorities/county programs. ♦ If requested information is unavailable, provide an explanation on the form and report the additional information as soon as it becomes available.

PROVIDER INFORMATION

Host area authority/county program:_____

Provider name:_____ Unit, ward or group home *(if applicable)*:_____

Address:_____ City:_____ County_____

Director / CEO:_____ Phone Number:_____

Provider Medicaid Number:_____ Facility License Number *(if applicable)*:_____

Name & title of first staff person to learn of incident _____

CLIENT INFORMATION

Date of incident: ____/____/____ Time of incident: ___: ___ ☐ a.m. ☐ p.m. Client Medicaid Number: _____

Client Date of Birth: ___/___/____ Client Gender: ☐Male ☐Female Weight:____lbs *(for deaths)* Height:____ft ____in *(for deaths)*

Client Ethnicity (*Check all that apply*)

☐ White ☐ Hispanic/Latino ☐ Black/African American

☐ Asian ☐ Native American ☐ Other *pecify)*:_____

All mh/dd/sa diagnoses: _____

_____

_____

Client's home area authority/county program *(if different from above)*:_____

Was the client treated by a physician for the incident? ☐ Yes ☐ No Date of treatment: _____/_____/_____

TYPE OF INCIDENT

DEATH

(Check only one)

Client death due to:

☐ Terminal illness or other natural cause

☐ Unknown cause

☐ SUICIDE

☐ ACCIDENT

☐ HOMICIDE / VIOLENCE

FOR ANY DEATH UNDERLINED ABOVE:

Complete the *Reportable Deaths* section, Page 2 *and* mail or fax a copy of this entire form to DFS Mental Health Licensure and Certification Section, 2718 Mail Service Center, Raleigh, NC 27699-2718. Fax: (919) 715-8077

ABUSE, NEGLECT, OR EXPLOITATION

(Check all that apply)

☐ Alleged abuse of a client.

☐ Alleged neglect of a client.

☐ Alleged exploitation of a client.

Verbally report any suspected case of abuse, neglect or exploitation of a consumer to the county Dept. of Social Services.

INJURY REQUIRING TREATMENT BY PHYSICIAN

(Check only one)

☐ Suicide attempt.

☐ Injury from use of a hazardous substance.

☐ Self-injury.

☐ Injury caused by another client.

☐ Other accident or injury.

MEDICATION ERRORS

Report medication errors that cause discomfort or that place a client in jeopardy

(Check only one)

☐ Missed dose of prescription medication.

☐ Wrong dosage administered.

☐ Wrong medication administered.

OTHER INCIDENTS

(Check all that apply)

☐ Client absence without notification for more than 3 hours.

☐ Suspension of a client from services.

Number of days suspended: _____

☐ Expulsion of a client from services.

☐ Arrest of a client for violations of state, municipal, county or federal law.

☐ Fire or equipment failure that has resulted in death or injury.

RESTRAINT & SECLUSION

Was the client restrained or in seclusion at the time of the incident? ☐ Yes ☐ No If yes, check applicable boxes below.

☐ Physically Restrained ☐ Chemically Restrained ☐ In Seclusion Duration: _____hours _____minutes

Only restraint or seclusion that results in abuse, neglect, injury or death needs to be reported on this form. However, all use of restraint or seclusion must be documented in the client's record, as required by the North Carolina Administrative Code. Providers using a standardized restraint & seclusion form are encouraged to submit that document with this form.

Did death occur within 7 days of restraint or seclusion of the client? ☐ Yes ☐ No

FOR ANY DEATH THAT OCCURS WITHIN 7 DAYS OF RESTRAINT OR SECLUSION, ***complete the Reportable Deaths section on Page 2 and immediately mail or fax a copy of this entire form to the DFS Mental Health Licensure and Certification Section, 2718 Mail Service Center, Raleigh, NC 27699-2718. Fax: (919) 715-8077***

Critical Incident and Death Reporting Form

Client Name:_____ **Client Social Security No:** _____ - ____ -_____ **Client ID No:**_____

REPORTABLE DEATHS

Complete only for deaths from suicide, accident, homicide, or violence or deaths occurring within 7 days of restraint or seclusion.

Address where client died: _____

Dates of last two (2) medical exams *(if known)*: _____/_____/_____ _____/_____/_____ Adjudicated incompetent?

Date of most recent admission to a state mh/dd/sa facility *(if known)*: _____/_____/_____ ☐ N/A ☐Yes ☐No

Date of most recent admission to a hospital for physical illness *(if known)*: _____/_____/_____ ☐ N/A

Physical illnesses/conditions diagnosed prior to death: _____

(attach additional pages as needed)

CIRCUMSTANCES OF INCIDENT

LOCATION OF INCIDENT

☐Provider premises ☐Client legal residence ☐School ☐Workplace ☐Community

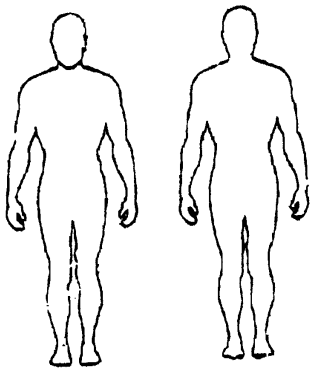
☐Other *(specify)* _____

DESCRIPTION OF INCIDENT

Include who (both participants and witnesses), what, why, and any other relevant information. ***(Attach additional pages if needed.)***

INJURY

On the figures below, circle the location of any bruises, cuts, scratches, injuries, or other marks that occurred as a result of the incident.



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INTERNAL RESPONSE

Describe any investigation done to determine the cause of the incident and projected date of completion. If investigation is not completed or necessary, explain why ***(attach additional pages as needed)*****:**

Describe any corrective measures that have been or will be put in place as a result of the incident and person(s) responsible for ensuring implementation ***(attach additional pages as needed)***:

Indicate other authorities or persons that have been notified of the incident ***(where applicable)***:

☐ County DSS Contact Name: _____ Date ____/____/____

☐ Law enforcement Contact Name: _____ Date ____/____/____

☐ Case Manager Contact Name:_____ Date ____/____/____

☐ Client's Home Area Program Date ___/___/___ ☐ DFS Mental Health Licensure & Certification Section Date ____/____/____

☐ Parent / Guardian Date ___/___/___ ☐ DFS Health Care Personnel Registry Date ____/____/____

☐ Other _____ Date ____/____/____

Name & title of person preparing report *(Please print)*:_____

Signature _____ Date _____/_____/_____ Time ____:____ ☐ a.m. ☐ p.m.

Confidentiality of client information is protected. Use this form according to confidentiality requirements in NC General Statutes and Administrative Code and in the Code of Federal Regulations.

Direct any questions to: DMH/DD/SAS Accountability Team Phone: (919) 881-2446 FAX: (919) 881-2451

Send all forms by mail, fax or protected email within 72 hours of incident to the host and home area authorities/county programs.

For reportable deaths, also send a copy of the entire form to the DFS Mental Health Licensure and Certification Section, 2718 Mail Service Center, Raleigh, NC 27699-2718. Fax: (919) 715-8077